# EXHIBIT I

#### UNITED STATE DISTRICT COURT EASTERN DISTRICT OF WISCONSIN GREEN BAY DIVISION

DANIEL MCGRAW, and SUSAN MCGRAW,	) )
Plaintiffs,	) Civil Action: 1:15-CV-1424-WCG
v. SUPERIOR AVIATION, LTD., KUBICK AVIATION SERVICES, INC., And QBE INSURANCE CORP.,	SUPERIOR AVIATION AND QBE INSURANCE CORPS' FIRST SET OF WRITTEN INTERROGATORIES AND DOCUMENT REQUESTS TO THE PLAINTIFF, DANIEL MCGRAW
Defendants.	) )

Pursuant to Fed. R. Civ. P. 33 and 34, within 30 days, the Defendants Superior Aviation LTD., and QBE Insurance Corp. hereby requests the Plaintiff, Daniel McGraw, answer the following written interrogatories and produce all of the documents and other things as described below:

#### **INSTRUCTIONS & DEFINITIONS**

Each of the following interrogatories shall be answered separately and fully, in writing, under oath, unless objected to and in which event the objection shall be stated in lieu of an answer. The answers, including objections, shall be signed by the party, officer or agent making them. The party upon whom the interrogatories and requests for the production of documents have been served shall serve a copy of the answers and objections within thirty (30) days hereafter, in accordance with Fed. R. Civ. P. 33 and 34. An evasive or incomplete answer is considered a failure to respond.

You are under a continuing duty to reasonably supplement your responses with respect to any questions directly addressed to the matter, and the identity of each person expected to be

called as a witness. Furthermore, you are under a similar duty to correct any incorrect responses when you learn it is incorrect.

- A. The term "You", "Your" or "Yourself" shall mean or refer to the Plaintiff **Daniel**McGraw and where appropriate, his consultants, agents, subagents, attorneys and any person or entity acting or purporting to act on her behalf.
- B. The term "Document(s)" shall mean any written, graphic or recorded material of every kind and description, however produced or reproduced, whether a draft or final, original or reproduction, signed or unsigned, regardless of whether approved, signed, sent, received, drafted or executed, that is in the possession, custody or control of **Daniel McGraw** or any of his agents, employees, officers, attorneys or any other person acting or purporting to act on his behalf.
- C. The term "Person" shall mean any natural person, corporation, partnership, association, joint venture and other business association, governmental or public body and/or other legal entities.
- D. The term "Communication" shall mean any and all forms of verbal or written intercourse.
- E. The term "Relating to" shall mean consist of, refer to, reflect or be in any way, legally, logically, or factually connected with the matter discussed.
- F. Whenever appropriate, the singular form of a word should be interpreted in plural. "And" as well as "or" shall be construed either disjunctively or conjunctively as necessary to bring within the scope of this request any document which might otherwise be construed to be outside of its scope. The past tense shall be construed to include the present tense and vice versa, to make the request inclusive rather than exclusive.

- G. The term the "Occurrence" or "Incident" refers to the accident involving your aircraft, N246AK, which occurred on May 6, 2014 that is the subject matter of Your Complaint.
  - H. The term "Defendant" shall mean Superior Aviation and/or QBE Insurance Corp.,
- I. The term "Lawsuit" or "Complaint" refers to the above captioned lawsuit filed by Plaintiff which is pending in the Eastern District of Wisconsin.
- J. If You contend that You are entitled to withhold from production any or all information or documents requested herein on the basis of the attorney-client privilege, the work product doctrine or any other ground, please provide a written statement with respect to each and every Document setting forth:
  - (i) the nature of the Document or information, e.g., letter or memorandum;
  - (ii) the date appearing on the Document or, if no date appears, the date on which the document was prepared;
  - (iii) the name of the Person(s) by whom the Document was written or prepared;
  - (iv) the name of the Person(s) to whom the Document was addressed;
  - (v) the name of each Person, other than the addressee(s) identified above, to whom the Document, or a copy thereof, was sent or with whom the Document was discussed;
  - (vi) the name of the Person who signed the Document, if signed;
  - (vii) a description of the subject matter of the Document;
  - (viii) the name of the Person who has custody of the Document; and
  - (ix) the basis upon which You contend You are entitled to withhold the Document from production.

#### INTERROGATORIES

Interrogatory No. 1: Identify the person answering these interrogatories, including Your full name (including any middle names), any aliases by which you have been known, address, date of birth and social security number, and any person(s) or entity with whom You have consulted in the preparation of Your answers to these Interrogatories.

Interrogatory No. 2: Identify each and every person whom you believe has knowledge or information relating to any of your claimed damages or injuries allegedly suffered as a result of the incident that is the subject matter of this case.

<u>Interrogatory No. 3:</u> Identify each and every maintenance facility, and/or mechanic, FAA certified or otherwise, which has either performed maintenance or inspections on your aircraft, N246AK, during your ownership.

Interrogatory No. 4: For each mechanic or maintenance facility identified in response to Interrogatory No. 3, to the best of your ability, state when they performed maintenance and/or inspections, and what maintenance and/or inspections were performed.

<u>Interrogatory No. 5:</u> If you have personally performed any maintenance or inspection on your aircraft, N246AK, please state when and what maintenance and/or inspections you performed.

Interrogatory No. 6: After your aircraft, N246AK, came out of its condition inspection on February 7, 2014, identify each and every time you are aware that its engine was started, run, attempted to run, or otherwise operated.

Interrogatory No. 7: Identify each and every fact upon which you rely in Paragraph 21 of your Complaint to assert that Superior Aviation performed an inadequate condition inspection.

Interrogatory No. 8: Identify each and every fact upon which you rely in Paragraph 22 of your Complaint to assert that Superior Aviation failed to exercise ordinary care in performing maintenance and/or a condition inspection on your aircraft, N246AK.

Interrogatory No. 9: Identify each and every fact upon which you rely in Paragraph 22 of your Complaint to assert that Superior Aviation failed to adequately inspect and repair your aircraft, N246AK.

Interrogatory No. 10: Identify each and every fact upon which you rely in Paragraph 22 of your Complaint to assert that Superior Aviation failed to follow Lanciar's condition inspection checklist when performing a condition inspection on your aircraft, N246AK.

Interrogatory No. 11: Identify each and every fact upon which you rely in Paragraph 22 of your Complaint to assert that Superior Aviation failed to exercise ordinary care in inspecting for line hose and clamp leaks on your aircraft, N246AK.

Interrogatory No. 12: Identify each and every fact upon which you rely in Paragraph 22 of your Complaint to assert that Superior Aviation failed to refrain from acts or omissions in conducting its business so as to expose you to an unreasonable risk of bodily injury or death.

Interrogatory No. 13: Identify each and every document upon which you will rely in support of your responses to Interrogatories 7 through 13.

Interrogatory No. 14: Identify each and every fact upon which you rely in Paragraph 26 of your Complaint to assert that Superior Aviation acted maliciously or in intentional disregard of plaintiff's rights so as to warrant the imposition of punitive damages under Wis. Stat. sec. 895.043.

<u>Interrogatory No. 15:</u> In your own words, please describe the injuries you allegedly suffered as a result of the subject incident.

Interrogatory No. 16: If you contend any of the injuries descried in Paragraph 15 are permanent in nature, please identify which injuries you allege are permanent and how they effect your daily living.

Interrogatory No. 17: State the name and address of each doctor, health care provider, or health care facility, including psychologists, psychiatrists, social workers, or counselors, from which you sought or are currently seeking treatment including the dates of treatment and the type of treatment sought.

#### **DOCUMENT REQUEST**

Request No. 1: Produce any and all records in your possession upon which you will rely to support you alleged damages.

Request No. 2: Produce any and all documents identified and/or relied up in responding to the above Interrogatories.

Request No. 3: Produce any and all logbooks in your possession for you aircraft, N246AK, including, but not limited to, airframe logbooks, engine logbooks, and/or propeller logbooks.

Request No. 4: Produce any and all maintenance records in your possession relating to your aircraft, N246AK, for the ten (10) years prior to the alleged incident that is the subject matter of this case.

Request No. 5: Produce your aircraft, N246AK's, Pilot's Operating Handbook, Airplane Flight Manual, or their equivalent.

Request No. 6: Produce any and all checklists in your possession that relate to the operation and/or maintenance of your aircraft, N246AK.

Request No. 7: Produce any and all documents in your possession that relate to your aircraft, N246AK's, emergency procedures.

Request No. 8: Produce any and all documents in your possession relating to build and/or manufacturing of the aircraft and the issuance of its special airworthiness certification.

Request No. 9:

Produce your pilot's Logbook.

Request No. 10: Produce signed copies of the attached 15 blank medical authorizations and please fill in your date of birth and social security number on each.

Request No. 11: Produce any and all documents referenced in your Rule 26(a)(1)

Initial Disclosures.

Dated this 17th day of March, 2016

WILSON ELSER MOSKOWITZ EDELMAN & DICKER LLP

Attorneys for Defendants Superior Aviation, LTD., and QBE Insurance Corp.

William J. Katt

State Bar No. 1001506

Mark C. Severino

State Bar No. 1074001

Address:
River Bank Plaza, Suite 600
740 N. Plankinton Avenue
Milwaukee, WI 53203
(414) 276-8816
william.katt@wilsonelser.com
mark.severino@wilsonelser.com

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	<del></del>
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy. It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 16 otherwise privileged information. If applicable diagnosis, procedure acquired immunodeficiency syndrodisease, cerebral palsy, mental retard of employment, scholastic and any All information and redesignees above named. It is under furnishing the previously mentiodiscovery purposes in the above-endiscovery purposes in the above-endiscovery purposes in the above-endiscovery purposes or organization must be authorization. By signing this authorization and that my records we released by persons or organization payment, enrollment or eligibility have a right to inspect or copy authorization.  I may revoke this author provider listed above. Revocation right to contest a claim under the pass already been released in respon or eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P. permission to examine and/or obtain photo static copies of any and all information sent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ted to transcripts, reports, records, billing records, writings and inquiries whether rehological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). action to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, one (AIDS), or human immunodeficiency virus (HIV), dental records, developmental relation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  cords you possess are to be disclosed to the persons, firms, corporations or their erstood that the undersigned will not be responsible for payment of any of the costs and records. All records obtained will be used for legal investigation and intitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Arization shall be as valid and acceptable as the original and applies to past and future be used within one year after the date hereof. I understand I may refuse to sign this horization, I understand that there is a potential of re-disclosure of protected health will no longer be protected under the federal privacy rule and may be further used or not receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this distribution to this authorization. In addit
Dated at(	, this day of, 2016.
	•

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	<sup>*</sup> <sup>*</sup>
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoint possession, including but not limit academic, medical, psychiatric, psy. It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 16 otherwise privileged information. If applicable diagnosis, procedure acquired immunodeficiency syndrodisease, cerebral palsy, mental retar of employment, scholastic and any All information and redesignees above named. It is under of furnishing the previously mentiodiscovery purposes in the above-entart Aphotocopy of this authorization. By signing this authorization. By signing this authorization and that my records we released by persons or organization payment, enrollment or eligibility have a right to inspect or copy a authorization.  I may revoke this author provider listed above. Revocation right to contest a claim under the pathas already been released in responder eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P. permission to examine and/or obtain photo static copies of any and all information tent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ted to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). attion to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, and (AIDS), or human immunodeficiency virus (HIV), dental records, developmental relation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Cords you possess are to be disclosed to the persons, firms, corporations or their erstood that the undersigned will not be responsible for payment of any of the costs oned records. All records obtained will be used for legal investigation and nititled case pending in The Eastern District of Wisconsin, Green Bay Division.  Arization shall be as valid and acceptable as the original and applies to past and future be used within one year after the date hereof. I understand I may refuse to sign this horization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or not receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand, all records received. I also understand I have a right to request a copy of this district policy. I also understand that the re
Dated at(	, this day of, 2016.

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	<b>-</b>
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LI requested regarding my past or pre allow them, or any physician apporpossession, including but not limit academic, medical, psychiatric, psy. It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 16 otherwise privileged information. if applicable diagnosis, procedure acquired immunodeficiency syndred disease, cerebral palsy, mental retator of employment, scholastic and any All information and redesignees above named. It is undof furnishing the previously mention discovery purposes in the above-endangement of this authorization. By signing this authorization. By signing this autinformation and that my records we released by persons or organization payment, enrollment or eligibility have a right to inspect or copy authorization.  I may revoke this author provider listed above. Revocation right to contest a claim under the phas already been released in response.	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, LP, permission to examine and/or obtain photo static copies of any and all information sent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ited to transcripts, reports, records, billing records, writings and inquiries whether yechological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.), zation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 60 & 164 and any other applicable statues requiring my full and informed consent for I further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, ome (AIDS), or human immunodeficiency virus (HIV), dental records, developmental ordation, epilepsy, autism, and seizures. This authorization is also valid for the release of other confidential records in your possession.  Records you possess are to be disclosed to the persons, firms, corporations or their erstood that the undersigned will not be responsible for payment of any of the costs oned records. All records obtained will be used for legal investigation and intitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Prization shall be as valid and acceptable as the original and applies to past and future be used within one year after the date hereof. I understand I may refuse to sign this horization, I understand that there is a potential of re-disclosure of protected health will no longer be protected under the federal privacy rule and may be further used or ms receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this rization in writing by sending a
Dated at	, this day of, 2016.
(	Uity and state)

DATE OF BIRTH:  SOCIAL SECURITY NO.:  CASE NUMBER:  15-CV-1424-WCG  TO:  I, Daniel McGraw, the undersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elses Moskowitz, Edelman & Dicker, LLP, permission to examine and/or obtain photo static copies of any and all informatio requested regarding my past or present physical condition and treatment rendered. The purpose of this authorization is tallow them, or any physician appointed by them, to examine and copy any and all records of any kind and sort in you possession, including but not limited to transcripts, reports, records, billing records, writings and inquiries whethe academic, medical, psychiatric, psychological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc., It is my intention by this Authorization to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.82 252.15, 804.10, 45 C.F.R. Parts 160 & 164 and any other applicable statues requiring my full and informed consent for otherwise privileged information. I further understand that the specific type of information to be disclosed may include if applicable diagnosis, procedure and treatment for physical, behavioral or psychiatric illness, transmitted disease; acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), dental records, development disease, cerebral palsy, mental retardation, epilepsy, autism, and seizures. This authorization is also valid for the releas of employment, scholastic and any other confidential records in your possession.  All information and records you possess are to be disclosed to the persons, firms, corporations or their designees above named. It is understood that the undersigned will not be responsible for payment of any of the cost of furnishing the previously mentioned records. All records obtained will be used for legal investigation and discovery purposes in the above-entitled case pending in The Eastern District of Wisconsin, Green Bay Division.  A photocopy of this authorization sha	PATIENT NAME:	DANIEL MCGRAW
CASE NUMBER: 15-CV-1424-WCG  TO:  I, Daniel McGraw, the undersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser Moskowitz, Edelman & Dicker, LLP, permission to examine and/or obtain photo static copies of any and all informatio requested regarding my past or present physical condition and treatment rendered. The purpose of this authorization is tallow them, or any physician appointed by them, to examine and copy any and all records of any kind and sort in you possession, including but not limited to transcripts, reports, records, billing records, writings and inquiries whethe academic, medical, psychiatric, psychological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc. It is my intention by this Authorization to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83 252.15, 804.10, 45 C.F.R. Parts 160 & 164 and any other applicable statues requiring my full and informed consent for otherwise privileged information. I further understand that the specific type of information to be disclosed may include if applicable diagnosis, procedure and treatment for physical, behavioral or psychiatric illness, transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), dental records, development disease, cerebral palsy, mental retardation, epilepsy, autism, and seizures. This authorization is also valid for the releas of employment, scholastic and any other confidential records in your possession.  All information and records you possess are to be disclosed to the persons, firms, corporations or their designees above named. It is understood that the undersigned will not be responsible for payment of any of the cost of furnishing the previously mentioned records. All records obtained will be used for legal investigation and discovery purposes in the above-entitled case pending in The Eastern District of Wisconsin, Green Bay Division.  A photocopy of this authorization shall be as valid and acceptable as the ori	DATE OF BIRTH:	
I, Daniel McGraw, the undersigned, hereby authorize and direct you to furnish the law firm of Wilson, Else Moskowitz, Edelman & Dicker, LLP, permission to examine and/or obtain photo static copies of any and all informatio requested regarding my past or present physical condition and treatment rendered. The purpose of this authorization is t allow them, or any physician appointed by them, to examine and copy any and all records of any kind and sort in you possession, including but not limited to transcripts, reports, records, billing records, writings and inquiries whether academic, medical, psychiatric, psychological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc. It is my intention by this Authorization to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.82 252.15, 804.10, 45 C.F.R. Parts 160 & 164 and any other applicable statues requiring my full and informed consent for otherwise privileged information. I further understand that the specific type of information to be disclosed may include if applicable diagnosis, procedure and treatment for physical, behavioral or psychiatric illness, transmitted disease; acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), dental records, development disease, cerebral palsy, mental retardation, epilepsy, autism, and seizures. This authorization is also valid for the releas of employment, scholastic and any other confidential records in your possession.  All information and records you possess are to be disclosed to the persons, firms, corporations or their designees above named. It is understood that the undersigned will not be responsible for payment of any of the cost of furnishing the previously mentioned records. All records obtained will be used for legal investigation and discovery purposes in the above-entitled case pending in The Eastern District of Wisconsin, Green Bay Division.  A photocopy of this authorization shall be as valid and acceptable as the original and applies to past and fut	SOCIAL SECURITY NO.:	
I, Daniel McGraw, the undersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elses Moskowitz, Edelman & Dicker, LLP, permission to examine and/or obtain photo static copies of any and all information requested regarding my past or present physical condition and treatment rendered. The purpose of this authorization is to allow them, or any physician appointed by them, to examine and copy any and all records of any kind and sort in you possession, including but not limited to transcripts, reports, records, billing records, writings and inquiries whether academic, medical, psychiatric, psychological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.) It is my intention by this Authorization to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.82, 146.82, 146.82, 804.10, 45 C.F.R. Parts 160 & 164 and any other applicable statues requiring my full and informed consent for otherwise privileged information. I further understand that the specific type of information to be disclosed may include if applicable diagnosis, procedure and treatment for physical, behavioral or psychiatric illness, transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), dental records, development disease, cerebral palsy, mental retardation, epilepsy, autism, and seizures. This authorization is also valid for the release of employment, scholastic and any other confidential records in your possession.  All information and records you possess are to be disclosed to the persons, firms, corporations or their designees above named. It is understood that the undersigned will not be responsible for payment of any of the cost of furnishing the previously mentioned records. All records obtained will be used for legal investigation and discovery purposes in the above-entitled case pending in The Eastern District of Wisconsin, Green Bay Division.  A photocopy of this authorization shall be as valid and acceptable as the original and applies t	CASE NUMBER:	15-CV-1424-WCG
Moskowitz, Edelman & Dicker, LLP, permission to examine and/or obtain photo static copies of any and all information requested regarding my past or present physical condition and treatment rendered. The purpose of this authorization is tallow them, or any physician appointed by them, to examine and copy any and all records of any kind and sort in you possession, including but not limited to transcripts, reports, records, billing records, writings and inquiries whether academic, medical, psychiatric, psychological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.) It is my intention by this Authorization to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83 (252.15, 804.10, 45 C.F.R. Parts 160 & 164 and any other applicable statues requiring my full and informed consent for otherwise privileged information. I further understand that the specific type of information to be disclosed may include if applicable diagnosis, procedure and treatment for physical, behavioral or psychiatric illness, transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), dental records, developments disease, cerebral palsy, mental retardation, epilepsy, autism, and seizures. This authorization is also valid for the release of employment, scholastic and any other confidential records in your possession.  All information and records you possess are to be disclosed to the persons, firms, corporations or their designees above named. It is understood that the undersigned will not be responsible for payment of any of the cost of furnishing the previously mentioned records. All records obtained will be used for legal investigation and discovery purposes in the above-entitled case pending in The Eastern District of Wisconsin, Green Bay Division.  A photocopy of this authorization shall be as valid and acceptable as the original and applies to past and futur records. This authorization must be used within one year after the date hereof. I understand I may r	TO:	
I may revoke this authorization in writing by sending a letter revoking the authorization to the health car provider listed above. Revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under the patient's policy. I also understand that the revocation will not apply to information the has already been released in response to this authorization. In addition, I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization.  Dated at, this day of, 2016.  (City and state)	Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authorize 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndro disease, cerebral palsy, mental retar of employment, scholastic and any All information and red designees above named. It is unde of furnishing the previously mentiod discovery purposes in the above-entant Aphotocopy of this authorization. By signing this authorization and that my records we released by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the path as already been released in respon or eligibility of benefits may not be	P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to nted by them, to examine and copy any and all records of any kind and sort in your ed to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Fords you possess are to be disclosed to the persons, firms, corporations or their artstood that the undersigned will not be responsible for payment of any of the costs used records. All records obtained will be used for legal investigation and attitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Frization shall be as valid and acceptable as the original and applies to past and future are used within one year after the date hereof. I understand I may refuse to sign this norization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I larceords received. I also understand I have a right to request a copy of this examinate to my insurance company when the law provides the insurer with the tient's policy. I also understand that the revocation will no

•

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL: requested regarding my past or present allow them, or any physician appoint possession, including but not limit academic, medical, psychiatric, psychiatri	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to nted by them, to examine and copy any and all records of any kind and sort in your ed to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.
designees above named. It is unde of furnishing the previously mentio	cords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs and records. All records obtained will be used for legal investigation and utitled case pending in The Eastern District of Wisconsin, Green Bay Division.
A photocopy of this authorization shall be as valid and acceptable as the original and applies to past and future records. This authorization must be used within one year after the date hereof. I understand I may refuse to sign this authorization. By signing this authorization, I understand that there is a potential of re-disclosure of protected health information and that my records will no longer be protected under the federal privacy rule and may be further used or released by persons or organizations receiving it without obtaining my authorization. I also understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I understand I have a right to inspect or copy all records received. I also understand I have a right to request a copy of this authorization.	
I may revoke this authorization in writing by sending a letter revoking the authorization to the health care provider listed above. Revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under the patient's policy. I also understand that the revocation will not apply to information that has already been released in response to this authorization. In addition, I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization.	
Dated at	, this day of, 2016.
(C	nty and state)

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. If applicable diagnosis, procedure acquired immunodeficiency syndrodisease, cerebral palsy, mental retar of employment, scholastic and any	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, IP, permission to examine and/or obtain photo static copies of any and all information sent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ted to transcripts, reports, records, billing records, writings and inquiries whether rechological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). action to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, ome (AIDS), or human immunodeficiency virus (HIV), dental records, developmental redation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.
designees above named. It is unde	cords you possess are to be disclosed to the persons, firms, corporations or their erstood that the undersigned will not be responsible for payment of any of the costs oned records. All records obtained will be used for legal investigation and ntitled case pending in The Eastern District of Wisconsin, Green Bay Division.
records. This authorization must be authorization. By signing this authorization and that my records we released by persons or organization payment, enrollment or eligibility or a significant payment.	orization shall be as valid and acceptable as the original and applies to past and future be used within one year after the date hereof. I understand I may refuse to sign this horization, I understand that there is a potential of re-disclosure of protected health fill no longer be protected under the federal privacy rule and may be further used or an acceiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this
provider listed above. Revocation right to contest a claim under the pa has already been released in respon or eligibility of benefits may not be	ization in writing by sending a letter revoking the authorization to the health care will not apply to my insurance company when the law provides the insurer with the atient's policy. I also understand that the revocation will not apply to information that use to this authorization. In addition, I understand that treatment, payment, enrollment e conditioned on obtaining this authorization.
Dated at	, this day of, 2016.  City and state)
. (6	City and state)

DANIEL MCGRAW
15-CV-1424-WCG
dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information sent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ited to transcripts, reports, records, billing records, writings and inquiries whether yehological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). Leation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 10.8 164 and any other applicable statues requiring my full and informed consent for I further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, one (AIDS), or human immunodeficiency virus (HIV), dental records, developmental relation, epilepsy, autism, and seizures. This authorization is also valid for the release of other confidential records in your possession.  Seconds you possess are to be disclosed to the persons, firms, corporations or their erstood that the undersigned will not be responsible for payment of any of the costs oned records. All records obtained will be used for legal investigation and intitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Porization shall be as valid and acceptable as the original and applies to past and future be used within one year after the date hereof. I understand I may refuse to sign this shorization, I understand that there is a potential of re-disclosure of protected health will no longer be protected under the federal privacy rule and may be further used on ms receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand all records received. I also understand I have a right to request a copy of this arient's policy. I also understand
nse to this authorization. In addition, I understand that treatment, payment, enrollmentee conditioned on obtaining this authorization.
, this day of, 2016.  City and state)

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	<b>""</b>
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL: requested regarding my past or pres- allow them, or any physician appoir possession, including but not limit academic, medical, psychiatric, psy. It is my intention by this Authoriza 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndro disease, cerebral palsy, mental retar of employment, scholastic and any  All information and red designees above named. It is unde of furnishing the previously mentio discovery purposes in the above-en  A photocopy of this author records. This authorization must b authorization. By signing this auth information and that my records we released by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this author provider listed above. Revocation right to contest a claim under the pa has already been released in respon or eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to noted by them, to examine and copy any and all records of any kind and sort in your ed to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.).  ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 2 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Fords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs med records. All records obtained will be used for legal investigation and titled case pending in The Eastern District of Wisconsin, Green Bay Division.  Trization shall be as valid and acceptable as the original and applies to past and future we used within one year after the date hereof. I understand I may refuse to sign this norization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this difference in the protected of the protected of the pr
((	City and state)

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndro disease, cerebral palsy, mental retar of employment, scholastic and any  All information and red designees above named. It is unde of furnishing the previously mentiod discovery purposes in the above-endiscovery purposes in the above-endant authorization. By signing this authorization. By signing this authorization and that my records we released by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the pathas already been released in respon or eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ed to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  For sords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs med records. All records obtained will be used for legal investigation and tittled case pending in The Eastern District of Wisconsin, Green Bay Division.  Fizzation shall be as valid and acceptable as the original and applies to past and future e used within one year after the date hereof. I understand I may refuse to sign this ionization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization to the health care will not apply to my insurance company when the law provides the insurer with the tient's policy. I also understand that the revo

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndrodisease, cerebral palsy, mental retar of employment, scholastic and any All information and redesignees above named. It is under of furnishing the previously mentiodiscovery purposes in the above-error A photocopy of this authorization. By signing this authorization. By signing this authinformation and that my records we released by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the pathas already been released in response.	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your led to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). Attoin to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Cords you possess are to be disclosed to the persons, firms, corporations or their erstood that the undersigned will not be responsible for payment of any of the costs and records. All records obtained will be used for legal investigation and attitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Trization shall be as valid and acceptable as the original and applies to past and future are used within one year after the date hereof. I understand I may refuse to sign this incrization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this distance is only insurance company when the law provi
Dated at	, this day of, 2016.
(4	

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndro disease, cerebral palsy, mental retar of employment, scholastic and any All information and redesignees above named. It is under of furnishing the previously mentiod discovery purposes in the above-error A photocopy of this authorization. By signing this authorization. By signing this authinformation and that my records we released by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the pathas already been released in respon	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to nted by them, to examine and copy any and all records of any kind and sort in your ted to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, and (AIDS), or human immunodeficiency virus (HIV), dental records, developmental relation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Cords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs and records. All records obtained will be used for legal investigation and attitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Trization shall be as valid and acceptable as the original and applies to past and future be used within one year after the date hereof. I understand I may refuse to sign this norization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this distributed in the provides the insurer with the a
Dated at	, this day of, 2016.
(0	City and state)

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	<sup>-</sup>
CASE NUMBER:	15-CV-1424-WCG
TO:	
Moskowitz, Edelman & Dicker, LL requested regarding my past or presallow them, or any physician appoir possession, including but not limit academic, medical, psychiatric, psy. It is my intention by this Authorizz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndrodisease, cerebral palsy, mental retar of employment, scholastic and any  All information and reddesignees above named. It is under of furnishing the previously mentiodiscovery purposes in the above-entartory authorization. By signing this authorization. By signing this authorization and that my records wireleased by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the pathas already been released in responder eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ed to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Cords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs and records. All records obtained will be used for legal investigation and utitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Trization shall be as valid and acceptable as the original and applies to past and future the used within one year after the date hereof. I understand I may refuse to sign this ionization, I understand that there is a potential of re-disclosure of protected health all no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this variety policy. I also understand that the revocation wil
Dated at	, this day of, 2016.

PATIENT NAME:	DANIEL MCGRAW
DATE OF BIRTH:	
SOCIAL SECURITY NO.:	
CASE NUMBER:	15-CV-1424-WCG
TO:	
I, Daniel McGraw, the und Moskowitz, Edelman & Dicker, LLz requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authorizz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. I if applicable diagnosis, procedure acquired immunodeficiency syndro disease, cerebral palsy, mental retar of employment, scholastic and any All information and red designees above named. It is unde of furnishing the previously mentiod discovery purposes in the above-entant Aphotocopy of this authorization. By signing this authorization and that my records wireleased by persons or organization payment, enrollment or eligibility of have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the pathas already been released in respon or eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to nted by them, to examine and copy any and all records of any kind and sort in your ted to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.). attion to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, me (AIDS), or human immunodeficiency virus (HIV), dental records, developmental dation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Cords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs oned records. All records obtained will be used for legal investigation and tittled case pending in The Eastern District of Wisconsin, Green Bay Division.  Trization shall be as valid and acceptable as the original and applies to past and future is used within one year after the date hereof. I understand I may refuse to sign this norization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization to the health care will not apply to my insurance company when the law provides the insurer with the tient's policy. I also understand that the revoc

PATIENT NAME:	DANIEL MCGRAW				
DATE OF BIRTH:					
SOCIAL SECURITY NO.:					
CASE NUMBER:	15-CV-1424-WCG				
TO;					
Moskowitz, Edelman & Dicker, LL requested regarding my past or pres allow them, or any physician appoi possession, including but not limit academic, medical, psychiatric, psy It is my intention by this Authoriz 252.15, 804.10, 45 C.F.R. Parts 160 otherwise privileged information. If applicable diagnosis, procedure acquired immunodeficiency syndrodisease, cerebral palsy, mental retar of employment, scholastic and any  All information and redesignees above named. It is under of furnishing the previously mentiodiscovery purposes in the above-endiscovery purposes in the above-endiscovery purposes in the above-endiscovery purposes in the above-endiscovery purposes or organization must be authorization. By signing this authorization and that my records we released by persons or organization payment, enrollment or eligibility have a right to inspect or copy a authorization.  I may revoke this authorization right to contest a claim under the pathas already been released in responder eligibility of benefits may not be	dersigned, hereby authorize and direct you to furnish the law firm of Wilson, Elser, P, permission to examine and/or obtain photo static copies of any and all information ent physical condition and treatment rendered. The purpose of this authorization is to inted by them, to examine and copy any and all records of any kind and sort in your ted to transcripts, reports, records, billing records, writings and inquiries whether chological, x-rays or other images (i.e., CT Scans, MRI, pathology slides/blocks etc.), ation to comply with Wis. Stats. Sections 51.30, 146.025, 146.81, 146.82, 146.83, 0 & 164 and any other applicable statues requiring my full and informed consent for further understand that the specific type of information to be disclosed may include, and treatment for physical, behavioral or psychiatric illness, transmitted diseases, and (AIDS), or human immunodeficiency virus (HIV), dental records, developmental relation, epilepsy, autism, and seizures. This authorization is also valid for the release other confidential records in your possession.  Cords you possess are to be disclosed to the persons, firms, corporations or their restood that the undersigned will not be responsible for payment of any of the costs and records. All records obtained will be used for legal investigation and atitled case pending in The Eastern District of Wisconsin, Green Bay Division.  Trization shall be as valid and acceptable as the original and applies to past and future we used within one year after the date hereof. I understand I may refuse to sign this norization, I understand that there is a potential of re-disclosure of protected health ill no longer be protected under the federal privacy rule and may be further used or as receiving it without obtaining my authorization. I also understand that treatment, of benefits may not be conditioned on my signing this authorization. I understand I all records received. I also understand I have a right to request a copy of this distributed by the protected of the payment, enrol				
Dated at	, this day of, 2016.				

CASE NO.:	15-CV-1424-WCG				
SOCIAL SECURITY NO:					
DATE OF BIRTH:					
PATIENT NAME:	Daniel McGraw				

TO: Ms. Connie Toby, FOIA Coordinator FAA Civil Aerospace Medical Institute Office of Aerospace Medicine, AAM-6 P.O. Box 25082
Oklahoma City, OK 73125

I, Daniel McGraw, the undersigned, hereby authorize and direct you to furnish, the Law Firm of Wilson Elser, LLP permission to examine and/or obtain photo static copies of any and all information which may be requested regarding my past or present physical condition and treatment rendered and to allow them or any physician appointed by them to examine and copy any and all records of any kind and sort in your possession, including but not limited to transcripts, reports, records, writings and inquiries whether academic, medical, psychiatric, psychological, x-rays or other images (i.e., CT Scans, MRI, pathology slides, etc.) and FAA pilot certification records and aerospace medical file which you may have regarding my condition or treatment. It is my intention by this Authorization to comply with HIPPA standards. I further understand that the specific type of information to be disclosed may include, if applicable diagnosis, procedure and treatment for physical, behavioral or psychiatric illness, or transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), dental records, developmental disease, cerebral palsy, mental retardation, epilepsy, autism, and seizures. This authorization is valid for the release of employment, scholastic and any other confidential records in your possession.

All information and records you possess are to be disclosed to the persons, firms, corporations or their designees above named. It is understood that the undersigned will not be responsible for payment of any of the costs of furnishing the previously mentioned records. All records obtained will be used for legal investigation and discovery purposes in the above-entitled case pending in The Eastern District of Wisconsin, Green Bay Division.

A photocopy of this authorization shall be as valid and acceptable as the original and applies to past and future records. This authorization must be used within one year after the date hereof. I understand I may refuse to sign this authorization. By signing this authorization, I understand that there is a potential of re-disclosure of protected health information and my records will no longer be protected under the federal privacy rule and may be further used or released by persons or organizations receiving it without obtaining my authorization. I also understood that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I understand I have a right to inspect or copy all records received. I also understand I have a right to request a copy of this authorization.

I may revoke this authorization in writing by sending a letter revoking the authorization to the health care provider listed above. Revocation will not apply to a patient's insurance company when the law provides the insurer with the right to contest a claim under the patient's policy. I also understand that the revocation will not apply to information that had already been release in response to this authorization. In addition, I also understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization.

Dated at		, this	day of	, 2016.
(Ci	ity and state)			